PHARMACY PLUS
A DEMONSTRATION PROGRAM UNDER SECTION 1115

STATE OF RHODE ISLAND
SUPPLEMENT C

STATE CONTEXT

I. Overview of Rhode Island Medicaid

Nearly one-third of Rhode Island's population of just over one million is age and income eligible for Medicaid benefits of one kind or another.[1] Although only about one-half of the eligible population regularly participate in Medicaid (about 167,000 recipients of a possible 337,000 in 2001), the program's expansive reach is one of the chief reasons the State's uninsured rate has been among the lowest in the nation for the last two years.[2] The benefits provided to RI Medicaid recipients are also quite broad; by some estimates, the State Medicaid program's benefit package is among the most comprehensive in the nation.[3] Given the scope of the program, it is no surprise that Medicaid is by far the State's largest budget item. In State Fiscal Year (SFY) 2003, Medicaid expenditures are projected to be about $1.6 billion, slightly less than 50% of total State spending for the year.

The greatest growth in RI Medicaid over the last five years has been the result of eligibility expansions in programs on the children and family side.[4] There have also been several increases in the scope of eligibility for the aged and persons with disabilities since 1997.[5] However, the number of recipients in this category has remained constant (51,000 in 1997 and 51,000 in 2001) and, as such, has declined as a percentage of the total Medicaid population in the last five years (51,000 of 124,000 or 41% in 1997 v. 51,000 of 167,000 or 30% in 2001).[6] Yet, in spite of its comparatively small size, the population of aged and disabled Medicaid recipients is responsible for two-thirds of the program's annual costs. For example, in 2001, benefits and services provided to the 51,000 Medicaid recipients who were eligible due to advanced age (i.e., age 65 or older) or disability (i.e., living with a chronic and disabling condition) accounted for 64% of total program expenditures ($735,000,000 of about $1.2 billion). Though expenditures for persons with disabilities were somewhat higher than those for the aged (53% v. 47%, respectively), institutional-level care (i.e., hospitals, nursing homes, and home and community-based services) accounted for about 83% of the total cost of services provided to members of both groups.[7]

II. RIx+ Target Population: Characteristics, Utilization and Coverage Trends

Despite the breadth of the Rhode Island Medicaid program, rising costs, particularly for Rx drugs, have reduced access to health care for some of the State's most vulnerable

residents. Among those most at risk are low-income Medicare beneficiaries who, although living on the margins of poverty, do not qualify for Medicaid benefits due to excess assets and/or income. As the chart below indicates, seniors in this group are by far the largest segment of the proposed **RIx +** pharmacy waiver target population.

RIX + TARGET POPULATION: MEDICARE BENEFICIARIES **TOTAL RI MEDICARE BENEFICIARIES[8]** **DECEMBER 2001=171,500**	
Income Qualified for RIx + (200% FPL or below)	83,000 (48%)
• **Aged**	75,530 (91%)
• **Disabled**	7,470 (9%)
Medicaid Eligible (SSI, Dual Eligible, Categorically Needy**)**	43,300 (52%)
Total Aged and Disabled Potentially Eligible for Waiver	39,700 (48%)
• **Total Aged Eligible for Waiver -**	34,000 (86%)
• **Total Disabled Eligible for Waiver –** Estimated 1/3 of CMAP population	627 or 11% of 5,560 Total Potentially Eligible Disabled
Total Medicare Beneficiaries Eligible for Waiver as Percent of Target Population of 37,000	**34,637** **94%**

As Medicare does not provide a pharmacy benefit for seniors living in the community, the escalating cost of prescriptions has not only strained the resources of most members of the target population, but of the State-funded programs and private health insurers they look to for assistance as well.

Until the late 1990s, the State's pharmacy assistance programs (i.e., RIPAE, CMAP and GPA) provided an adequate measure of prescription coverage to most low-income residents ineligible for Medicaid. However, in the last several years, it has become increasingly more apparent that these programs are too limited in scope to meet the growing demand for high cost prescription medications. For example, in RIPAE, both the number of enrollees and their Rx utilization rates have increased only marginally since 1999; by contrast, total expenditures per enrollee have risen sharply during the same period, by upwards of 51% per annum on average.

Medicare + Choice, Medi-gap and employer-based health plans that offer various levels of pharmacy coverage are declining in number and increasing in cost, even though still available to many Medicare beneficiaries in Rhode Island.[9] According to one account, in 2001, an estimated 85% of the State's 171,500 Medicare beneficiaries had one form or another of private supplemental or alternative health coverage:

- Thirty-three percent (56,600) were enrolled in a Medicare HMO;
- Twenty-one percent (36,000), had a privately or employer purchased Medi-gap plans; and
- Thirty-one percent, (53,165) were covered through an employer-based retiree health plan.[10]

About 40% of those enrolled in these plans were reportedly provided with a pharmacy benefit – i.e., 50% of Medicare + Choice and employer-based retiree plan enrollees, and 20% Medi-gap enrollees. By contrast, in 1996, 90% of the State's Medicare beneficiaries had alternate health coverage (over half through retiree plans) with more than two-thirds enrolled in plans that included a pharmacy benefit.

Declining enrollment in alternative and supplement health plans is due, at least in part, to the fact that there are fewer employers and insurers offering seniors and retirees health benefits today than in the past. There is evidence that the increasing cost of coverage has also played an important role, however. For example, average annual out-of-pocket costs for health plans including Rx benefits have climbed steadily over the last few years. By one account, out-of-pocket expenses for prescription medication coinsurance and deductibles alone have doubled in the last three years to an estimated average of $860 per annum, excluding premiums; this figure is about $200 more a year than most seniors spend on all other health care services and supplies combined.[11] In short, many of those living on a fixed income or at the threshold of poverty cannot afford to pay the premiums and out-of-pocket expenses now required to obtain and maintain pharmacy coverage.

At this juncture, there is no data available that evaluates the enrollment trends of Medicare beneficiaries by population (aged v. disabled) or by income. As a result, it is not possible to state with any degree of certainty how many members of the target population are enrolled in health plans that provide prescription medication coverage. The State's best estimate, based on data collected through RIPAE for the purposes of coordinating benefits, is that approximately 30% of the target population has at least a limited pharmacy benefit. Though monthly premiums vary by plan, the average annual cost for a Medi-gap plan with a generous pharmacy benefit (i.e., open-formulary, no benefit cap, minimal co-pays) is $3,100; for a Medicare + Choice plan providing broad Rx coverage, the annual premium cost is $1,525. With the exception of public employee retiree health plans, the average cost of employer-based coverage falls in the mid-range between the Medicare + Choice and Medi-gap plans with the most comprehensive prescription benefit packages.[12] In sum, with a median annual income of $13,000, paying the premiums for even the least expensive of these plans, along with annual out-of-pocket prescription costs of close to $900, may have put other forms of coverage out of the financial reach for the 70% of the target population expected to be without a pharmacy benefit.

DEMONSTRATION RESEARCH DESIGN AND HYPOTHESES

I. Purpose

The State's primary purpose in pursuing a Pharmacy Plus Section 1115 Medicaid Waiver is to provide both the elderly and individuals with disabilities the prescription medications they need to maintain their health and independence. Rhode Island, like many other states, is now in the midst of fiscal crisis that threatens the continued viability of several of its most effective human service programs, including Medicaid. Given these fiscal constraints, expanding the State's existing prescription programs is not a viable option at this time. Through a Pharmacy Plus Waiver, the State will be able to leverage existing funds to gain the resources required to provide a comprehensive prescription benefit to low-income seniors and, at least initially, a limited number of its most vulnerable, seriously ill residents.

It is important to note that current budget limitations prevent the State from including in the waiver many of the individuals living with disabilities who would otherwise meet the eligibility criteria for RIx +coverage. Once the necessary State resources become available, the waiver, if approved, will be amended accordingly.

Although the primary purpose for seeking the waiver is to assist Rhode Islanders in need, increasing access to prescription medications has the potential to yield more far-reaching benefits. Specifically, the State stands to gain significantly if the improvements in health status associated with greater use of prescription medications result in a decrease in the utilization of more expensive forms of health care. As recently as five years ago, there was not sufficient empirical evidence to support the existence of a direct linkage between access to affordable prescription coverage and consumption of other costly health care services. Since then, the influx of several new classes of highly efficacious, and pricey, therapeutic drugs into the health care market-place has resulted in marked improvements in general health status, particularly for the elderly with chronic conditions. Consequently, there is now a compelling body of research showing the linkage between Rx coverage, prescription medication utilization, and the need for and use of other forms of care. [13]

For example, one recent study reported that seniors with Rx coverage not only fill more prescriptions than those without it (18 v. 27 on average annually), but both self-report their health as better and use fewer other costly services to prove it – e.g., lower hospitalization and nursing home admissions rates. The study also found that low-income seniors with continuous pharmacy coverage had much lower out-of-pocket health care expenses than those without a Rx benefit and, as such, were more likely to have the

financial resources required to remain in the community when their health began to decline. [14]

Recent trends in heath care expenditures in state Medicaid programs, Rhode Island's included, suggest use of prescription medications can yield cost savings as well. Some states have reported that elderly Medicare beneficiaries with Rx coverage spend-down for Medicaid eligibility as medically needy far less often and that, when they do become eligible, most require fewer days of expensive institutional care. Moreover, states that have limited Medicaid prescription benefits as a cost-savings measure have found that spending related to hospitalization and emergency room visits increased at much faster pace than in the period before the cuts were made.[15] Current utilization patterns in the RI Medicaid program tend to support these findings. The available data indicate that per case per month (PCPM) expenditures for prescription drugs utilized by the State's aged Medicaid population (income up to 100% FPL) have gone up by about 8% each year since SFY 1999. Over this same period, PCPM cost for institutional level care (nursing homes, hospitals, home and community-based services) have declined by a total of 10%. Although there are several other factors known to have contributed to these trends (e.g., a slight drop in the size of the eligible population), these data provide reasonably reliable evidence that a linkage exists between prescription medication access and the utilization of institutional levels of care.

II. Demonstration Hypothesis and Research Design

Given the findings note above, the State expects the RIx + waiver, if approved, to broaden access to Rx coverage, improve health status and decrease reliance on and utilization of more expensive forms of care. These are, in some sense, the goals that the Pharmacy Plus waiver program was designed to achieve.

However, there are certain financial risks attendant with expanding access to and utilization of services through the **RIx +** waiver. Of specific concern is the high cost of many of the most efficacious prescription medications now on the market and the possibility that expanding access to coverage will result in inefficient and/or inappropriate patterns of utilization. Accordingly, the State is interested in demonstrating the following:

1. Effective pharmacy benefits management, including a disease-centered prior authorization system, will limit growth in PCPM annual pharmacy expenditures, improve health status, and promote efficient and responsible utilization of prescription medications by members of the target population enrolled in the waiver; and

2. Use of cost-sharing system that provides incentives for use of generic medications will decrease reliance on expensive brand name drugs and, in doing so, will assist in containing the costs of higher prescription drug utilization.

The data used to test these two hypotheses is available through the State's Medicaid Management Information System (MMIS).

Pharmacy Benefits Management: Hypotheses #1

> *Can effective pharmacy benefits management, including a disease-centered prior authorization system, both improve health and contain the costs of higher of prescription medication utilization?.*

At present, the average per member cost of prescriptions for the aged and disabled Medicaid population is about $1,475 per year, including those residing in the community as well as institutions. According to one source, the average cost of prescriptions for Medicare + Choice enrollees living in the community is estimated at $1,260 per annum.[16] Given the high Rx utilization rate of Medicaid recipients (approximately 37 per year) in comparison to that of Medicare beneficiaries (reportedly 28 per year), the State Medicaid program appears to be utilizing resources more effectively than Medicare + Choice plans, even though the latter often include a variety of cost-saving mechanisms (e.g., closed formularies, deductibles and co-insurance). The efficiency of the Rhode Island Medicaid program is due in part to advantageous drug rebates, but also to the effectiveness of its pharmacy benefits management program and prior authorization system.

As the State plans to incorporate both of these mechanisms into the **RIx+** waiver system, PCPM expenditures for the target populations should be comparable. Accordingly, the State will evaluate data on Rx utilization and expenditures for **RIx +** enrollees relative to the Medicaid population of aged and disabled as whole to determine whether similar efficiencies occur. Data to be included in the evaluation include: PCPM Rx costs, prescriptions filled per annum, percent subject to prior authorization system protocols and average increase in utilization and expenditures for members of the target population over-time.

Generic Drug Utilization: Hypotheses #2

> *Will the lower co-payments for generic prescription medications included in the waiver's cost-sharing scheme decrease enrollee utilization of more expensive name brand drugs over-time?*

Another factor that has contributed to the comparatively low cost of Rx coverage in the State's Medicaid program is the requirement that prescriptions be filled with generic drugs whenever available. Although many of the newer and more efficacious medications now on the market are single source, name brands, a substantial number of the prescription drugs the elderly use most often are available in generic form.

The State has found that the reluctance of recipients to accept generic substitutes is one of the chief reasons utilization of multi-source medications remains high. Several studies have reported that health plan enrollee concerns about generic drugs can be readily over-come if education about their effectiveness is provided at the point-of

service. Similarly, commercial plans have found that enrollee reservations about generic drugs become a less important factor when co-pays for well-known name brand alternatives are set substantially higher.[17]

In order to maximize limited waiver resources, the State plans to use both education and lower co-payments to encourage enrollees to utilize more generic prescription medications. The potential savings are significant. It is not uncommon for a name brand medication to cost three or more times as much as a generic alternative.[18] As one of the central goals of the waiver is to promote responsible utilization, the State will be tracking the number of prescriptions filled with generic substitutes on a continual basis. In addition to focusing on actual overall prescription expenditures, the State will assess the probable change in waiver costs if prescriptions were filled with generic medications in every instance in which they were available. The State intends, as well, to examine the cumulative impact of generic drug and pharmacy benefits management on utilization and average annual PCPM prescription costs.

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[1] Number of total eligible Rhode Islanders based on income and age data from the 2000 census as reported by the Rhode Island State Planning Commission.

[2] According to the U.S. Center of Population Studies (CPS), Rhode Island's uninsured rate was the lowest in the nation in 2000 and 2001 at about 6%; in addition, the State ranked first in the nation in percent of children with health coverage – 98% with coverage and only 2% uninsured. Data reported in the Rhode Island Governor's Advisory Council on Health , *Annual Report 2001*, (www.gov.state.ri.us/GAC_hlth/).

[3] Based on an analysis of the services provided to recipients, both the AARP and Urban Institute reported that the State's Medicaid program was the eighth most generous in the U.S. in 2000 and 2001.

[4] In 1997, there were 73,000 children and families covered by Medicaid; by end of the 2001 calendar year, the number of Medicaid recipients in this population had reached 116,000, an increase of nearly 59% in just five years.

[5] Eligibility was extended up to 100% of the FPL in SFY 2001. Most other expansions were the result of Home and Community-Based Services waivers and have had only a modest impact on the total number of eligible recipients in the population.

[6] Data Source for RI Medicaid unless otherwise indicated is RI Department of Human Services, Division of Health Care Quality, Financing and Purchasing, Office of Contracting and Payments.

[7] The per capita per month (PCPM) cost of institutional level care for both groups far exceeded that for all other providers combined (includes physicians and other professionals, pharmacy and behavioral health). For the aged, nursing home PCPM costs were the highest whereas for persons with disabilities, PCPM expenditures for home and community based services took the top spot.

[8] Source: Data derived from Medicare Enrollment Files, Centers for Medicare & Medicaid Services (CMS) located at http://cms.hhs.gov/statistics/enrollment/; State Health Facts Online, Henry J. Kaiser Family Foundation located at http://statehealthfacts.kff.org; and RI Department of Human Services, Division of Health Care Financing and Purchasing.

[9] Although enrollment in Medicare + Choice and Medi-gap plans has decline by 20% since 1999, Rhode Island has not experienced the mass exodus of plans from the market that has occurred in other states.

[10]Source: Congressional Research Service, *Regional Variations in Medicare Beneficiary Coverage.* Report prepared for the Select Committee on Health, July 2002. Note: As the data for this report were compiled from a variety of different sources and then re-calculated to based on national figures, the findings are best viewed as a reflection of enrollment trends rather than actual enrollment

[11] See: Congressional Budget Office (CBO). *Projections of Medicare and Prescription Drug Spending*, Statement of Daniel L. Crippen, CBO Director, before the Committee on Finance, US Senate (3/7/02) located at http://www.cbo.gov/showdoc.cfm?index=3304&sequence=0 and Gross, David, *Medicare Beneficiaries and Prescription Drugs: Costs and Coverage*, AARP Public Policy Institute, Data Digest #77 (09/02).

[12] Estimates based on insurer filings provided by the Rhode Island Department of Business Regulation, Insurance Division.
[13] For a review of these studies and findings see: Kaiser Family Foundation, *Medicare and Prescription Drug Coverage: A Chartpack*, (June 12, 2002). (www.kff.org/content/2002/6048/); Merlis, Mark, *Explaining the Growth in Prescription Drug Spending: A review of recent studies* (Report prepared for the U.S. Department of Health and Human Services, August 2000). (www.aspe.hhs.gov); National Conference of State Legislatures, *Medicaid Prescription Drug Laws and Strategies for 2001-2002.* (www.ncsl.org/program/health/medicaidrx.htm), (updated 9/02); and Gross, D. and Brangan, N., *Out-of-Pocket Spending on Health Care by Medicare Beneficiaries Age 65 and Older: 1999 Projections*, PPI Publication IB#41 (AARP, December 1999)
[14]See Gross, D. AARP (9/02).
[15] See Crippen, D. CBO Testimony (3/02)
[16] Ibid.
[17] Source: Verispan Scott-Levin Source ™, Prescription Audit: Special Data Request, 2001;
[18] See: National Conference of State Legislatures, *Medicaid Prescription Drug Laws and Strategies for 2001-2002.* (www.ncsl.org/program/health/medicaidrx.htm), (updated 9/02).